

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031179

STATE FILE NUMBER

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7756

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED AUG 28 1961

1. a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 1/2 Mo.	
c. CITY OR TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 7519 Wellington Way	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle ANN Last TRUITT		4. DATE OF DEATH Month Aug 19 Day 1961 Year	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/7/1897
9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired clerk		10b. KIND OF BUSINESS OR INDUSTRY St. L. Co. Clerk	
11. BIRTHPLACE (City and state or country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY US	
13a. FATHER'S NAME John T Truitt		13b. MOTHER'S MAIDEN NAME Catherine Tighe	
14. NAME OF HUSBAND OR WIFE —		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. INFORMANT Mrs Clarence L Wolff, 7519 Wellington Way		Address	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of caecum</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>153.0</u>		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>July 15</u> to <u>Aug 19, 1961</u> and last saw her alive on <u>Aug 19, 1961</u> Death occurred at <u>11:17</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deed or title) <u>Alan W. O'Fee M.D.</u>	
22b. ADDRESS <u>100 N Euclid</u>		22c. DATE SIGNED <u>Aug 21, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/22/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis</u>	
24. FUNERAL DIRECTOR <u>Louise Popp Inc</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 21 1961</u>	
26. REGISTRAR'S SIGNATURE <u>Kalussed Mo</u>		27. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Herbert J. Lane Jr.*

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.